MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

**Friday, March 21, 2003**
**9:03 a.m.**

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID DURENBERGER
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:
Experience with market competition in fee-for-service
-- Anne Mutti

MS. MUTTI: This presentation is intended to give you a sense of our workplan in the area of exploring experience using market competition in fee-for-service Medicare. We hope to give you a sense of a draft paper that we will give you in advance of the April meeting. I think this presentation also follows nicely on some of the things that you've just discussed in relation to Karen's presentation because we touch a lot on demonstrations, and the lessons learned, in their role and the future of them, as well as get into the centers of excellence concept which builds nicely on some of the quality discussions that you've just had.

But we do approach this particular presentation from a market competition point of view so the question that we first posed in starting out is, can market competition be used to price fee-for-service Medicare products and service? And if so, how should it be designed?

Not only has Congress required demonstrations testing competitive bidding, but legislation has also been introduced that would require competitive bidding to determine prices for such things as durable medical equipment and laboratory services nationally. There's also been conceptual discussions about how you might use it to price Part B drugs.

So to begin to consider this question we thought it would be helpful to review Medicare's experience with at least two key demonstrations, the competitive bidding for DME demonstration and the participating heart bypass center demonstration. That one was the most comprehensive demonstration of the two that looked at the centers of excellence concept back in the 1990s.

Last September Sharon presented the results of the initial evaluation of the DME competitive bidding demonstration to you. As you may recall, the demonstration was in operation between 1999 and 2002 in two sites, Polk County, Florida and San Antonio, Texas. Each site tested bidding for a different subset of DME products and the bidding rules varied somewhat based on the specific product. In all cases, beneficiaries had choice among winning bidders.

A total of three rounds of bidding were conducting, and while the evaluations are not complete, results from the first two years of the demonstration indicate that on average prices were lower than the fee schedule and quality and access in general were not compromised. In fact the three rounds of bidding resulted in prices that averaged between 17 and 21 percent below the fee schedule.

While on the whole access and quality appear unchanged under the demonstration, two situations, at least two caught the attention of evaluators. There was one concern in Polk County that there was a decline in the proportion of beneficiaries receiving portable oxygen, which is an issue in terms of their quality of life. And there one issue that they noted in San Antonio where some complaints were that equipment wasn't being

adequately serviced. In response, beneficiaries used other bidders that were available to them.

The Medicare participating heart bypass center demonstration was conducted between 1991 and 1996. This demo invited physician and hospital organizations nationwide to offer a price for the total hospital and physician services surrounding two cardiac DRGs. 209 hospitals responded to the solicitation, 42 of which submitted very thorough applications and ultimately seven sites were selected.

In return for the lower payment the participating sites received two key rewards. First, they were paid a bundled fee for all hospital and physician services, and this includes consulting physicians, surrounding those DRGs. This bundled fee allowed participating organizations to create a payment approach that rewarded physicians for reducing the total cost of care. It aligned their incentives so that they shared in the savings that were accruing to the hospital before. They had the incentive to use perhaps lower cost supplies in the OR, to improve the discharge time from the ICU.

Second, facilities could market themselves as having this national distinction that recognized that they provided high quality service in these areas and they could potentially use this as a way to market themselves and gain greater market share in their local market. This demonstration did prove to reduce spending on the bypass patients that it served by about 10 percent, and many of the
participating sites did respond to the incentives and considerably reduced their own costs. In addition, mortality rates declined.

In the paper that we're preparing for April we plan to identify some of the key issues that appear relevant to any competitive bidding proposal and examine how each of the two demonstrations approach them. Specifically, we plan to look at each of the demonstrations with respect to the following key elements.

First, how the market is defined. This includes questions about how you would define the product, how comparable the product is across providers and suppliers, the degree of bundling of services and products that were in each demonstration, and then we'll also talk about the geographic boundaries of the market and how that was defined as well as who were the eligible participants to play in this market.

A second design issue is how the bidding process is created and what incentives are in place for competitive bids. We'll talk about the specifics of the bid solicitation under each demo as well as the carrots and sticks, or the rewards and penalties, that each pursued to induce competitive bids, and their relative success.

We'll also highlight in this discussion some of the transition policies, in particular in the DME demo that were pursued . One interesting one was the concept of allowing some losing bids, in this case for oxygen suppliers, to continue to serve their current patients, but not take on new Medicare beneficiaries for the term of the contract.

Finally, we'll examine how each of the demonstrations provided for the education of beneficiaries and providers, and what protections were in place for beneficiaries who had concerns and needed problems addressed.

In the course of looking at this issue we wanted to also point out to you today that despite the savings achieved for beneficiaries in the program in these two demonstrations neither program is in operation, and I guess that's not a surprise considering some of the comments that you've made already. As of January 1st the reduced rates paid to DME suppliers in the two sites were increased to the statewide fee schedule. In a way, I think the demonstration proved that the fee schedule is broken.

CMS no longer has the legislative authority to selectively contract with winning bidders, and this is a key element to the demonstration.

The fate of the centers of excellence concept has been more complicated. As we noted, the bypass demonstration ended in '96. Recognizing its success and the utility of expansion, CMS issued an RFP in 1998 to expand the concept to more sites and more procedures, including orthopedic procedures. It was under a new name at this point, centers of excellence. 100 facilities responded but the timing was poor for CMS. They were facing the Y2K preparations and then they also had BBA coming down the pike and had staffing constraints.

So it was relaunched in 2000 and targeted to three states. Apparently there was a fair amount of interest although CMS would not share with me how many respondents they got on this round. They also report that the discounts were not as deep as they had been in the past. They said that prospective applicants had concern about the physician payment reductions that they thought might be coming down the pike, and also concern about whether the drug-eluding stents were going to be reclassified in a higher paying DRG. Both of those issues have been subsequently resolved but in the interim, before they were resolved, all interest in participating in that round of the demonstration dissipated, so to date there are no immediate plans anyway to continue with that demonstration concept.

Although there is a related demonstration that has been announced by the Secretary but has not been approved by OMB, and this was in response to an unsolicited proposal by some hospitals in Virginia, the Virginia cardiac surgery initiative. In this demonstration that they are contemplating it would be paying the bundled payment but there would not be the same kind of quality requirements, in particular, the volume of services that were evident in the bypass demonstration and planned for in the provider partnerships demonstration.

So given the significant investment in infrastructure of both demonstrations and the initial success each has had in preserving quality while reducing costs for beneficiaries in the program, commissioners may want to consider recommending that these demonstrations be continued. The DME, you may want to recommend that at a minimum the sites be continued in their current locations, or you could suggest that they be expanded to other sites. And there's certainly the notion that there could

be a national option also.

Staff plan to give further thought and analysis as to how expansion may best be pursued for the April meeting. In particular, Sharon is looking at measures of local markets competitiveness for DME and we'll present those results at the next meeting.

Reasons for not recommending continuation is a belief that the isolated incidents of compromised quality and access are severe enough from this demonstration to warrant termination of the demo and resumption of the higher payment rates.

You may also be concerned, and I know this was mentioned back in September about the magnitude of administrative costs. The cost of administering the DME demo as reported in the second evaluation that has come out subsequent to our last meeting was estimated to be about $4.8 million, while the savings of the demo amounted to $8.5 million. So more than half of the savings in this demo were offset by the administrative expense. But the evaluators are quick to note that the fixed costs would be defrayed over more sites and could increase the return substantially.

Another point to keep in mind is that we are still waiting for the last part of the evaluation on this demo that is due later this year.

As a parallel point, you may want to consider recommending that the Secretary continue to test the concept of paying a discounted bundled payment as a means of promoting cost effective delivery of high-quality care.

So we are interested in hearing your thoughts on the direction of this draft paper/chapter and the potential recommendations. Then we would become your thoughts on potential future research issues. One thing that's certainly on our mind is getting a better handle on the experience of other purchasers in using these type of approaches; whether they're using them now, have used them in the past, what's been the evolution. That could help inform our thoughts on this also.

MS. DePARLE: Anne, thank you for an excellent report. This is an area where I think that MedPAC could really play an important role. I think that if you walk around Washington, everyone says that to the extent that people are still supportive of fee-for-service Medicare, we have to get away from administered pricing. These are the demonstrations that have been done to try to figure out how to do that. I think that the research I've seen and what Anne presented today convinces me that they are moving in the right provide direction. But it has been extremely difficult.

I think if we talk to Senator Durenberger's former colleagues, there were only a handful who really have kept the faith on this and kept pushing it even though everyone says, this is the direction we want to go. It's one of those, not in my backyard, it's a classic not in my backyard issue. So I would urge us to be supportive of this and try to help both the Congress and the agency to move in this direction and to do more here, because we will never see how Medicare can move beyond administered pricing unless can do a better job of trying these

things out. As I said, I think they've shown that they can be successful.

MR. HACKBARTH: Anne, did you say that there's one more evaluation report due on the DME demo? When is that due?

MS. MUTTI: It's required to be six months after the completion of the demo, but I think it's not unlikely that it might slip a little bit. So that would be in six months, or actually less, in four or so.

DR. REISCHAUER: Is that covering only San Antonio or is it covering both of them, Polk and San Antonio

MS. CHENG: The third evaluation would revisit Polk. Especially they'd like to do some more investigation of how Polk compares to the county -- they have Brevard County and they've done similar surveys of beneficiaries to see what the impact of access and quality has been. So they have a comparison county. So they will explore some more differences and similarities between Polk and Brevard. The third report will focus on San Antonio, and do the first round of those surveys and find out how San Antonio compared to its comparison counties.

MR. HACKBARTH: I guess my off-the-cuff reaction is that it's appropriate to wait for the final evaluation to come in. But if it's consistent with the findings to date, then just to recommend extension of the same demos seems inappropriate. We'd be falling back into the S-HMO model, let's have perpetual demonstrations.

If the results are as we've heard so far, then we ought to be moving towards implementation and not towards continued demonstrations.

MS. DePARLE: That's what I meant to say. But at this point there isn't even support for moving forward with the demonstrations it seems, or at least there's certainly not enthusiastic support for it.

DR. REISCHAUER: I'm very sympathetic with that conclusion, but at the same time I wonder whether Polk County, Florida and San Antonio are representative of all of the environments one might find. I defer to whatever it is, Big Bear Lake --

DR. WAKEFIELD: Devil's Lake.

DR. REISCHAUER: Devil's Lake, excuse me -- might be a little different as might New York City. When we do our analysis I think that's one of the questions we should ask which is, do we know enough to pull the trigger and say, let's go nationwide on this? I'm sympathetic to doing that if the results come out as they do.

The other thing I'd like to know is whether we really have enough information from these demonstrations for the Congressional Budget Office to do a good cost estimate of this? Your description of implementation, administrative costs, which I really was an issue I threw onto the table in the past, is a very important one. Getting some kind of idea about what the scale of that would be if you went nationwide, I would think you could do it a lot more efficiently on a per whatever it is basis than just doing it in two counties. To the extent that something like this can overcome the natural political obstacles, it's going to be because somebody makes the proposal and the Congressional Budget

Office estimates that you can save $11.6 billion over the next 10 years and Congress is desperately looking for ways to save money within the Medicare program without disadvantaging beneficiaries.

MR. HACKBARTH: Other comments?

The evaluations, I assume will address what the necessary market characteristics are to make this concept work. I vaguely recall that was part of the earlier evaluation.

MS. CHENG: They certainly did try to get a sense of how competitive the market already was in the demonstration areas, to get a sense of how competitive it was for various lines of DME. One thing to remember about this benefit is that providers who may compete in one line, oxygen supplies, may in fact not compete in hospital beds or wheelchairs. So there are several different things to consider if you're going to competitively bid DME, about how to measure the relative competitiveness of a market, and they have looked at that.

One of the things that we hope to be able to bring you too is also a first cut at a description of DME markets across the country. We're going to try to look at some other MSAs and some statewide rural areas. It's going to real initial, but also to see how many counties look like Polk and how many MSAs look like San Antonio.

MS. MUTTI: At least initially they had hoped to do a rural site for the demonstration. That hasn't happened, so I think they're limited in some ways in evaluating the experience that they've had in the two sites that they have. I don't know how far they can take that and comment about how it would work in different markets.

MR. HACKBARTH: I'm trying to think of precedence. I'm not talking about demonstrations but within the actual operation of the program where we've selectively implemented a change in methodology like this one and say, in particular circumstances, particular market conditions, we can handle something differently than we might in, say, a rural area where there's less competition. I guess I can't think of any examples of that off the top of head.

MS. DePARLE: I guess it's usually characterized as a demo when they do that. I know the PPOs demos they're now doing it's pretty big. They've chosen certain areas of the country. I don't know whether they have the authority to do it that way or not.

This will need congressional ascent, buy-in -- Joe, that should be my word, not yours. But it's going to need that. In any event, they're going to have to work with the Congress and they might as well get some sort of legislative authority. But I think we can help support the effort.

MR. HACKBARTH: This is perhaps another example of people have talked about how Medicare needs to operate more like private payers and needs the legislative authority, CMS needs the authority to distinguish among different situations and say, this will work in place A. It may not work in place B. But there's no reason why we should overpay everywhere because this idea won't work in every single market.

MS. DePARLE: Right. There might be some markets -- I know

I've seen some research on this. I wonder if it was a GAO report. Do you all remember having seen a GAO report on this that evaluated maybe Polk County? Anyway, I think they did some work on looking at the markets. I know CMS, in fact Lu Zawistowich when she was there, in respect to the competitive pricing demos for managed care, they did exhaustive market analysis, perhaps more focused on managed care plans. But in any event, there's a lot of that available. I don't think anyone thinks that you can do the very same thing in every area, so there will have to be some more flexibility here. But the problem is what you said, Glenn, there's been a lot of talk, but that's all it gets is lip service.

DR. NEWHOUSE: I'd like to raise a new front. Should we be talking about the possibility of competition in lab, and conceivably, some degree in radiology as films can be digitized and sent around?

MR. HACKBARTH: As potential demonstration areas?

DR. NEWHOUSE: Yes.

DR. REISCHAUER: Anybody have a handle on what Medicare reimbursement for a lab test is relative to what private payers do? If you look at the lab, the growth of lab services it's very, very low. The methodology that we've used to update --

MS. DePARLE: I think it is lower than private payers, and they're doing a negotiated rulemaking I think right now on this.

DR. REISCHAUER: That's what I suspected. I thought, go to competition and raise the price?

MS. DePARLE: Maybe we're not paying enough. There are those situation too. I wouldn't say that about labs necessarily.

DR. ROWE: I need to make sure I'm here at the beginning of these meetings. With respect to radiology and the digitization comment, the capacity to do that is related to IT systems called PACs basically, which are expensive, very, very effective, very impressive capacities. You basically have a filmless radiology lab and you can move the images around. A physician in his or her office who sends a patient for an x-ray will get the x-ray on their computer in their office in addition to a note from the radiologist, et cetera.

But it's a little bit like computerized physician order entry. That is, for any given film or any given examination the cost may be very limited but there's a big capital expense for the hospital to go and put this in. So I would think that for us to pay more for systems like that on a per-exam basis would probably not be that helpful to hospitals because they would have a big upfront capital investment and they wouldn't trust that Medicare wouldn't reduce the rate later and they couldn't recover their capital investment.

So from that point of view I think that's probably a different -- that may be one of the things Mary mentioned earlier, we're prodding people to do the right things and with the GME money or something maybe that's something we could do there. I don't know if it reduces errors but it certainly is more efficient.

MR. MULLER: It's also contained inside the DRG for an awful lot of the Medicare activity.

DR. NEWHOUSE: But the DRG is an administered price.

MR. MULLER: But then you'd have to move that whole price around that component.

MS. MUTTI: We'd be happy at the next meeting to come back to you with a little more information, especially on the lab idea.

DR. NEWHOUSE: It may be a cockamamie idea. I just wanted to raise it. If it gets shot down, that's fine.

MS. MUTTI: Certainly some thought has been put into it already.

MR. HACKBARTH: In terms of our recommendations that we'll take up in April, one approach would be to have a conceptual recommendation that endorses the concept of competitive bidding and in the text we could say, examples that may be explored for future demos are A, B, and C. Then a second recommendation that is specific to DME and what we think ought to be done there. There we may even wish to wait for the final evaluation before we make a formal recommendation.

MR. MULLER: I'd just make a similar point. I think, as Anne's presentation indicated, this has been -- and Nancy-Ann's comments -- this has been a long time coming and it's moved very slowly. Doing this on products like DME or on drugs and so forth that can be seen as discrete products it's probably a little easier than something that's integrated into the pattern of care like radiology where you -- and especially in light of HIPAA, you don't even want to start thinking about all the consequences of trying to figure out how to take digitized images out of one care setting to another and getting consent and so on. So I think I would continue to focus on more discrete products that are not as integral to the care process as things like radiology exams, and certainly DME fits into that.

You talk about politics. You probably get into the politics of drugs even -- take Bob's comments and put an exponential function on them. But those are things that are probably easier to think about competitive bidding on than things that are so cohesive to the process.

MR. HACKBARTH: The potential political problems are very real and daunting, although it seems to me that part of our function is that bad we are to be guided not by the potential political problems but rather say, this is a wise, prudent direction for the program to move. It reduces costs, enhances quality, whatever. There are other people paid to worry about the political problems. I don't want to sound hopelessly naive in saying that, but I don't think we ought to be saying, we can't do this because it's just politically too difficult. That's a judgment for the people to make.

MR. MULLER: I agree with that. I'm just saying if you use a kind of criteria, where is that a lot of money, what's discrete products? I mean, pharmaceuticals are a good place to look, and that's all I'm saying.

MR. HACKBARTH: My comment wasn't specifically about radiology. I agree with the points you made there, in fact. But I don't want us to get hung up too much on the politics.

DR. MILLER: Can I just say one thing? Anne, what I am

taking away from this is, in our agenda as we think about alternatives to administered pricing I'm hearing some interest in exploring labs, radiology, you've brought up drugs. I just want to make sure that for the next meeting, I'm not going to promise that we're going to have labs wired out to present here.

MS. MUTTI: Right, especially not in a paper.

DR. MILLER: But I hear an agenda and as we hit the summer you may see some of this work that you're asking for here. I just think to hit the next meeting and the June report it would be a little tough.

MR. HACKBARTH: To be real specific on DME, my inclination, as I said is that we ought to be moving towards implementation. I do think that any recommendation we made in that direction will have more force if we wait for the final evaluation of the demonstration. So if that means we don't have a recommendation in the June report, so be it.

Thank you.